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LAS VEGAS, NEVADA 89117
702 933-9393 fax 702 933-6789

THOMAS & BIGLER
KNEE & SHOULDER INSTITUTE

☐ Gregory T. Bigler, M.D.
☐ Steven C. Thomas, M.D.

PATIENT INFORMATION

Acct #: ______________________

Last Name: ______________________
First Name: ______________________ Middle Initial ______
Social Security: ______________________
Address: ______________________
City: ______________________ State: ______
Zip: ______________________

Home Tel #: ______________________
Work Tel #: ______________________
Cell #: ______________________
Sex: ☐ M ☐ F
Birth Date: ______________________
Email: ______________________

Race: ______________________
Language Spoken: ______________________
Ethnicity: ☐ Hispanic/Latino ☐ Not-Hispanic/Latino
☐ Refuse to Report
Referred By: ______________________
Your Primary Care Physician: ______________________
How did you hear about us? ______________________

Marital Status: ☐ M ☐ S ☐ D ☐ W
Patient's Employer: ______________________
Occupation: ______________________
Patient's Employment Status: ☐ Full-Time ☐ Part-Time
☐ Retired ☐ Self Employed ☐ M Active Duty ☐ Not Employed
Patient's Student Status: ☐ Full-Time ☐ Part-Time
☐ Not a Student

(If Patient is a minor)

Responsible Party: ______________________
Address: ______________________ City: ______________ State: ________ Zip Code: ______________
Phone: ______________________ Employer: ______________________
Email: ______________________

NEXT OF KIN INFORMATION OR EMERGENCY CONTACT

Name: ______________________ Relationship: ______________________
Address: ______________________ Phone (please circle) ______________________ Home/Cell

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Date of Injury: ______________ Body Part: ______________ Attorney Name: ______________

Work Comp? ☐ Yes or ☐ No Is this an Auto Accident? ☐ Yes or ☐ No State where accident occured ______________

PRIMARY INSURANCE INFORMATION			SECONDARY INSURANCE INFORMATION		
Name of Insurance Co.	Phone Number	Effective Date	Name of Insurance Co.	Phone Number	Effective Date
Insurance Company Claims Address			Insurance Company Claims Address		
Name of Policy Holder	Relationship to Patient		Name of Policy Holder	Relationship to Patient	
Policy Holder's SS#	Date of Birth of Policy Holder		Policy Holder's SS#	Date of Birth of Policy Holder	
Policy ID	Group ID		Policy ID	Group ID	
Policy Holder's Employer			Policy Holder's Employer		
Employer Address			Employer Address		

I hereby authorize payment of medical benefits to KNEE & SHOULDER INSTITUTE for services furnished me. I also authorize the physician to release any information in the course of my examination or treatment. This assignment will remain in effect until revoked by me in writing. A photocopy of this agreement is to be considered as valid as the original. I hereby accept financial responsibility for all charges incurred whether or not I have insurance coverage. I hereby consent to and authorize medical treatments, tests, and procedures that my physician deems advisable and necessary based on his judgement.

Patient's Signature or Responsible Party Signature ______________________ Date ______________